PRISON H ALTH SERVICES: AUTHOR.ZATION LETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Op Orthopedics Referral	**Effective Dates:**	07/22/2005 to 09/22/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	3
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	15266125	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: _____ Date _____ Time

Reviewed and Signed By
Medical Director: _____ Date _____ Time

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

Form must be Complete and Legible. You must Type or Print

DEMOGRAPHICS

Site Name & Number: Staton 843

Site Phone #: (334) 567-1548

Site Fax #: (334) 567-1538

Patient Name: (Last, First): Martin, Marlon

Alias: (Last, First):

Inmate #: 225145

SS Number: 041-78-3810

Date: (mm/dd/yy): 7.20.06

Date of Birth: (mm/dd/yy): 12.17.70

PHS Custody Date: (mm/dd/yy): 09.13.2002

Potential Release Date: (mm/dd/yy): 12.20.2000

Will there be a charge? ☒ Yes ☐ No

Sex ☒ Male ☐ Female

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☐ Physician ☒ NP, PA ☐ Dental

McArthur

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy): ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: 1 ☐ Other:

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

MRI (R) knee Aug 12 @ 11am

Diagnosis:

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

(R) knee pain & recurrent edema. ACL repair 2004 Seen by Dr. Chung 4/05 & new injury.

Results of a complaint directed physical examination:

Dr. Chung suspects meniscus tear.

Previous treatment and response (including medications):

NSAIDS, Braces, Activity restriction

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class:

CPT code:

UR Auth #: 152535241

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	**Effective Dates:**	04/07/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14881640	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

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P.O. Box 967
Brentwood, TN 37024-0967

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Clinical Summary or Attached Report

S/p (R) knee ACL reconstruction 9/15/2004 Reinjury 2/2005 - still has pain - giving way -
Exam 0°-120° flex - (+) tender. (L) anterior lateral joint line - ⊘ instability.
Dx ? meniscus tear
Rec Cont exercises - MRI (R) knee and RTC ō same

*** **For security and safety, please do not inform patient of possible follow-up appointments.** ***

Signature of Consulting Physician: [signature] 4/27/05
Date Time

Reviewed and Signed By Medical Director: 4-27-05 [signature]
Date Time

☐ Sanders M. Benkwith, M.D.
☐ James R. Glassner, M.D.
☐ Tom Lyle Mitchell, Jr., M.D.
☐ John L. Swan, M.D.
☐ Michael B. Bradford, O.D.
☐ Fred B. Setzer, O.D.
☐ Timothy M. Meadows, O.D.
☐ Zelda
☐ Sturbridge
☐ Prattville
☐ Vision Exam & Eye-Health Screening
☐ Work In
☐ Post-Op Visit
☐ Int/Short Exam

Name: Marten, Marten Acct.# 23505 KILBY Date: 4/22/05 Age: ____ M F

CC/HPI

4/0 ↓ SUP VF OS / SUDDEN, PAINLESS IN JAN 05
Ø HX TRAUMA / Ø HEALTH HX ABNORMALITIES

Eye Meds

Sys. Meds

FH

VA
OD
OS

NEAR

Current RX
OD
OS

AR
OD
OS

C C

Adnexa/Eyelids: ☐ nl
Pupils: ☐ nl
Muscles: ☐ nl

T OD
OS
@ 11:30

Dilate with:
☐ N
☑ M
☐ C

MR OD
OS

CR OD
OS

SLE: LLLS&C ☐ nl
Cornea ☐ nl
AC ☐ nl
Lens ☐ nl
IOL/PC ☐ nl
Iris ☐ nl

Fundus: Optic Nerve ☐ nl rims 40-50% C/D OD-WNL
Macula ☐ nl
Vessels ☐ nl OS-PAVE (9)
Periphery ☐ nl

VF R - WNL
L - SUP LOSS

Impressions:
OPTIC NERVE ATROPHY OS - HEALTHY PATIENT Ø OCULAR HX

Plan:
REFER FOR NEURO WORKUP - OPTIC ATROPHY OS

Letter to: ____ Signature: ____ MD/OD ☐ Over for Notes

MEP

EYE EXAMINATION SHEET

TO: (Service Physician)	FROM: (Requesting Ward, Med. Fac. Phys.)	Date of Request:
Bradford	Staton	4/22/05

Reason For Request: (Complaints and Finding)

Past History

Old Rx

Signature

Type of Consult ☐ Emergency ☐ Routine

CONSULTATION REPORT

Subjective: OD / OS

OPHTH:

New Rx: OD / OS

Seg. Ht.

Ext:
Date Dispensed & Initials:

Seg. Type: PLANO / POLYCARB

IDP & Time: PLANO FTW PD 63

5/20/05

Frame:
Size:
Color:

4/22/05

OPTOMETRIST'S SIGNATURE

Patients Last Name	First	Middle	Age	R/S	ID No.
Martin,	Marlon				225145

F-65 Rev. (1-95)

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

...must be Complete and Legible. You must Type or Print.

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843	Patient Name: (Last, First,) Martin, Marlon	Date: (mm/dd/yy) 3/21/05
Site Phone # (334) 567-1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) 12/17/70
Site Fax # (334) 567-1538	Inmate # 225145	PHS Custody Date: (mm/dd/yy) 09/18/02
Will there be a charge? ☒ Yes ☐ No / Sex ☒ Male ☐ Female	SS Number 041-78-3610	Potential Release Date: (mm/dd/yy) 12/20/06

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):_____

CLINICAL DATA

Requesting Provider: ☐ Physician ☒ NP, PA ☐ Dental

MS Arthur

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other:_____

Number of Visits/Treatments: 3

Specialist referred to: Dr. Chung

Type of Consultation, Treatment, Procedure or Surgery: Ortho April 27, 05 @ 2:30 p

Diagnosis: ACL repair

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:
S/P (R) ACL repair.
Seen By Dr. Chaung 3/18/05 who requests F/U in 3 weeks

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: __/__/__

FAXED 3/31/05 (tt)

4/6/05 (tt)

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: / Med Class:	CPT code:	UR Auth #:

PRISON HEA CH SERVICES: AUTHORIZA N LETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	**Effective Dates:**	04/07/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14881640	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

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P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
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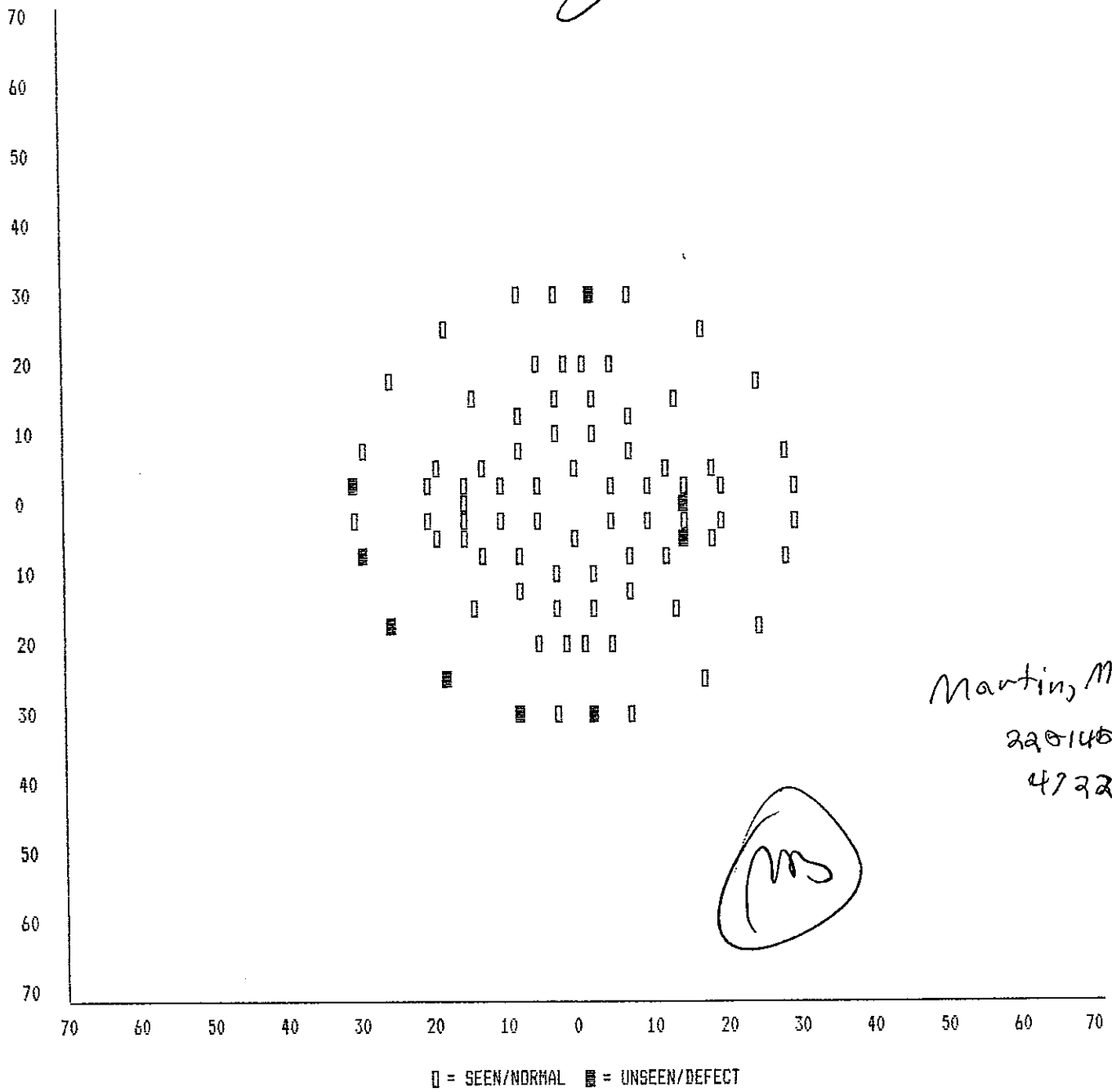
Clinical Summary or Attached Report
***** For security and safety, please do not inform patient of possible follow-up appointments. *****
Signature of Consulting Physician: Date Time
Reviewed and Signed By Medical Director: Date Time

Patient _____	RIGHT EYE TEST	Date	04/22/05
Stimulus...Automatic	Pattern.....CENT 30	Total Points...	82
Duration.. 0.4 Sec.	Strategy....CONTOUR SUPRA	Presentations..	98
Interval.. 0.9 Sec.	Options.....None	False Posit.....	2/3
Backgrnd.. 31.5 Asb.	DB Offset...5	False Negat.....	0/0
Patient Age.... 34	Correction _____	Fixation.....Mosaic	
IOP _____	Pupil Size _____	Elpsd Time: 2 m 36 s	



Martin, Marlon
220146
4/22/05

SYNEMED INC.
BENICIA, CA 9451(
OPTIFIELD IB (v2.21

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Martin, Marlon		
Service Authorized:	Office Visits: Outpatient Optometry Referral	**Inmate Number:**	225145MA
Effective:	Visits authorized for 60 days from effective date.	**Effective Dates:**	02/03/2005 to 09/03/2005
Responsible Facility:	Staton Correctional Facility	**Visits Authorized:**	1
Authorization Number:	14660018	**Contact Name:**	Michelle Pope
		Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

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Clinical Summary or Attached Report

S/p 9/04 – ACL reconstruction – Has been on, while he slipped – twisted his @ knee 3-wk ago
Ex Wound healed – No [illegible] Rom – 0° – 120° flex
ф instability to stress
R Please give him a hinged knee brace.
Exercises to strengthen his knee – rtc in 3 wk

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician: [signature] Date 3/18/05 Time

Reviewed and Signed By Medical Director: [signature] 3/2/06 Date Time

UTILIZATION M[illegible]AGEMENT REFERRAL R[illegible]VIE[illegible] FORM

rm ...st be Complete and Legible. You must Type o[illegible]nt

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843	Patient Name: (Last, First,) MARTIN, MARLON	Date: (mm/dd/yy) 03/16/05
Site Phone # (334) 567-1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy)
Site Fax # (334) 567-1538	Inmate # 223145	PHS Custody Date: (mm/dd/yy)
Will there be a charge? ☐ Yes ☐ No / Sex ☐ Male ☐ Female	SS Number	Potential Release Date: (mm/dd/yy)

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

WINFRED Williams

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

History of illness/injury/sypmtoms with Date of Onset:

S/P ACL Repair w/ Re-injury, Fall 2004

Results of a complaint directed physical examination:

Joint instability, PAIN & EFFUSION. ROM limited to 20° FLEX

Previous treatment and response (including medications):

ACL Repair, Profiles, crutches.

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: _____ ☐ Other:_____

Specialist referred to: Dr Chung

Type of Consultation, Treatment, Procedure or Surgery:

ORTHOPEDICS Consult F/u
6336 Winton Blount Blvd Knee XRay

Diagnosis: KNEE PAIN
ICD-9 code: 719.46-315.00

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: / Med Class:	CPT code:	UR Auth #:

PRISON HEALT SERVICES: AUTHORIZATIO ETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Outpatient Optometry Referral	**Effective Dates:**	02/03/2005 to 09/03/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14660018	**Telephone Number:**	(334)395-5973 Ext 14

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Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: Date Time

Reviewed and Signed By
Medical Director: Date Time

HCX

HEALTHCARE CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

MOU

DO 3/8/05

INSTITUTION: Staton

Name: Martin, Marlon

State ID No: 225145

DOB 12/17/70

Race: B Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
W. Williams, MD	3/14/05				

HISTORY/DIAGNOSIS:

Edema

X-RAY REQUEST

ABDOMEN/KUB	FINGERS	NAVICULAR VIEW	SOFT TISSUE STUDIES
ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)	FOOT	ORBITS	STERNUM
ANKLE	HAND	OS CALCIS (HEEL)	TEMPORO-MANDIBULAR JOINTS
CERVICAL SPINE	HIP	PELVIS	THORACIC SPINE
CHEST PA / LATERAL	HUMERUS	RADIUS/ULNA	TIBIA/FIBULA
COCCYX	X KNEE (Rt)	RIBS	TOES
CONE DOWN SELLA TURCICA	LUMBAR SPINE	SACRO-ILLIAC JOINTS	WRIST
ELBOW	MANDIBLE	SCAPULA	ZYGOMA
FACIAL BONES	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

REPORT

Martin

RIGHT KNEE: The patient has had an anterior cruciate ligament repaired. The orthopedic hardware remains in place. The joint space is maintained with no fracture or dislocation.
IMPRESSION: PREVIOUS SURGERY INVOLVING THE KNEE.

D: & T: 03-16-05 Maurice H. Rowell/jhi Board Certified Radiologist (Signature on file)

3/16/05 (W)

KH, RT.

X-RAY TECHNOLOGIST'S NAME (PRINT) | X-RAY TECHNOLOGIST'S SIGNATURE | DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT) | RADIOLOGIST'S SIGNATURE | DATE SIGNED

EYE EXAMINATION SHEET

TO: (Service Physician) Dr Bradford

FROM: (Requesting Ward, Med. Fac. Phys.)

Date of Request: 1/28/05

Reason For Request: (Complaints and Finding)

OD 20/15 s̄ glasses
OS 20/200 OU 20/20

unable to Read

Past History: Reports sudden loss of ½ VF (sup) OS x 7d - clearing slightly now

Old Rx

Signature

Type of Consult ☐ Emergency ☐ Routine Ø prev vis prob

CONSULTATION REPORT

Subjective: OD OS

OPHTH:

New Rx: OD OS

Seg. Ht.

Ext:
Date Dispensed & Initials:

Seg. Type: PLANO

Trop 1% ī st 00/03

IDP & Time:

60 to 40 / Periph w/n (indirect monocular)

Frame:
Size:
Color:

KILBY EYE CLINIC
DFE/SLE/VF

MB 1/28/05

OPTOMETRIST'S SIGNATURE

Patients Last Name	First	Middle	Age	R/S	I D No.
Martin,	Marlon		34		225145

12/17/70

F-65 Rev. (1-95)

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: Staton 843 STATON

Patient Name: (Last, First) MARTIN Marlon

Date: (mm/dd/yy) 01/11/05

Site Phone #: (334) 567 - 1548

Alias: (Last, First)

Date of Birth: (mm/dd/yy) 12/17/70

Site Fax #: (334) 567 - 1538

Inmate # 225145

PHS Custody Date: (mm/dd/yy) 12/10/02

Will there be a charge? ☒ Yes ☐ No

Sex ☒ Male ☐ Female

SS Number 041-78-3610

Potential Release Date: (mm/dd/yy) 12/20/06

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dental

Wilfred Williams

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

History of illness/injury/symptoms with Date of Onset:

Visual loss (L) eye

unable to see print - Lg on eye chart

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DX)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:

Results of a complaint directed physical examination:

(R) 20/15

(L) 20/200+ - unable to READ

Specialist referred to: Dr Bradford

Previous treatment and response (including medications):

Conservation.

Type of Consultation, Treatment, Procedure or Surgery:

Opthamology Eval.

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

FAXED 1/12/05

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

PHS
PRISON HEALTH SERVICES INCORPORATED

~~PROGRESS NOTES~~

Date/Time	Inmate's Name: Martin, Marlon #225145 D.O.B.: 12/17/70
1/3/05	S/P (R) knee ACL reconstruct 9/15/04
	ø pain
	Ex Wound healed
	ø tender.
	0° – 110° flex
	ø instability.
	XR → good.
	P Rec. Knee brace
	Exercise
	RTC prn
	[signature]
	[initials] 1/4/05

UTILIZATION M. AGEMENT REFERRAL REVI. V FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843	Patient Name: (Last, First,) Martin, Marlon	Date: (mm/dd/yy) 10,21,04
Site Phone # (334) 567 - 1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) 12,17,70
Site Fax # (334) 567 - 1538	Inmate # 225145	PHS Custody Date: (mm/dd/yy) 12,10,02
Will there be a charge? ☒ Yes ☐ No / Sex ☐ Male ☐ Female	SS Number 041-78-3610	Potential Release Date: (mm/dd/yy) 12,20,06

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dental

WINFRED D. WILLIAMS

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to: Dr. Chung

Type of Consultation, Treatment, Procedure or Surgery:
Follow-up Ortho (1 month)
Take xrays
1/3 @ 2:00pm

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:

S/p (R) knee ACL reconstruction on 9/15/04 per Dr. Chung.

Results of a complaint directed physical examination:

0° - 90° flexion per Dr. Chung.

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: __/__/__

FAXED 10/21/04 EE

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY:

Cert Type:	Med Class:	UR Auth #: 1433673

PRISON HEAL d SERVICES: AUTHORIZAT ON LETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	**Effective Dates:**	09/22/2004
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14214370	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

f/u @ knee arthroscopy [illegible]
Ex Wound healed. 0°–90° flex.
R Remove clips.
Please get him a hinged knee brace full range.
Exercise.
RTC 1 month

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: [signature] 10/15/04
Date Time

Reviewed and Signed By Medical Director: 10/18/04 [signature]
Date Time

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843	**Patient Name: (Last, First)** Martin, Marlon	**Date: (mm/dd/yy)** 09/20/04
Site Phone # (334) 567 - 1548	**Alias: (Last, First)**	**Date of Birth: (mm/dd/yy)** 12/17/70
Site Fax # (334) 567 - 1538	**Inmate #** 225145	**PHS Custody Date: (mm/dd/yy)** 12/10/02
Will there be a charge? ☐ Yes ☒ No; **Sex** ☒ Male ☐ Female	**SS Number** 041-78-3610	**Potential Release Date: (mm/dd/yy)** 12/2/06

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☐ Physician ☒ NP, PA ☐ Dental

Martin CRNP

~~Facility Medical Director Signature and Date:~~

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 09/01/04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:_____

Specialist referred to: Dr. Chung

Type of Consultation, Treatment, Procedure or Surgery:

F/u from surgery 10/15 @ 2:45 PM
Dr Chung 2 wks

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:

S/p ACL repair - Rt

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

FAXED

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

PRISON HEAL H SERVICES: AUTHORIZAT N LETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	**Effective Dates:**	09/22/2004
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14214370	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

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Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
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Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: Date Time

Reviewed and Signed By
Medical Director: Date Time

09/2

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: Staton 843

Patient Name: (Last, First,) MARTIN, MARLON

Date: (mm/dd/yy) 08/20/04

Site Phone # (334) 567 - 1548

Alias: (Last, First,)

Date of Birth: (mm/dd/yy) 12/17/70

Site Fax # (334) 567 - 1538

Inmate # 225145

PHS Custody Date: (mm/dd/yy) 12/10/02

Will there be a charge? ☒ Yes ☐ No

Sex ☒ Male ☐ Female

SS Number 041-78-3610

Potential Release Date: (mm/dd/yy) 12/19/04 12/20/06 -DS

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dental

WINFRED D. WILLIAMS

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

History of illness/injury/sypmtoms with Date of Onset:

KNEE PAIN "GIVING OUT"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☒ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:

Results of a complaint directed physical examination:

PAIN W/ AMBULATION, UNSTABLE GAIT, SWOLLEN (R) KNEE, ANT. DRAWER (+)

ORTHO EVALUATION → ACL TEAR (R) (8/17/04)

DR. CHUNG M

Specialist referred to: Dr. Chung

Previous treatment and response (including medications):

NSAIDS, ELEVATION, REST

Type of Consultation, Treatment, Procedure or Surgery:

ACL REPAIR W/ PATELLAR TENDON GRAFT.

Baptist East 9/15 @ 730am

Baptist East

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

FAXED 8/20/04 FT

☐ More Information Requested: (See Attached)

Date resubmitted: __/__/__

☐ Resubmitted with requested information.

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Martin, Marlon	**Inmate Number:**	225145MA
Service Authorized:	Office Visits: Op Surgical Followup Referral	**Effective Dates:**	07/22/2004
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14004434	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

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For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
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Clinical Summary or Attached Report

(R) Knee MRI 7/12/04 by report → ACL tear. He still has giving way in the knee

Discuss ACL reconstruction c̄ patellar tendon graft - Risks include anesthesia infection, neurovascular damage, incomplete return of stability in the knee, weakness of patellar tendon, post-op thrombophlebitis or pulmonary embolism. He would like to go ahead. ~~Please send his MRI pictures to my office.~~ Will schedule when approved.

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: [signature] Date: 8/17/04 Time:

Reviewed and Signed By Medical Director: 8/17/04 [signature] Date Time: 8 3 40 P

562-7167

Add essograph Plate 1

Martin, Marlon
Surgery - Sept. 15, 04

Baptist Medical Center East
PHYSICIAN'S ORDERS

USE BALL POINT PEN ONLY AND PRESS FIRMLY!!

ALLERGIES

CHT Order # Transcriber Initials/Time	Date/Time Ordered		ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT MAY BE DISPENSED UNLESS CHECKED OR INITIALED	PHYSICIAN'S ORDERS AND SIGNATURE

ROUTINE PRE OPERATIVE ORDERS

DR _____

Page 2 of 2

3 **EKG:**

_____ MVP/murmur or other valve disorder
_____ Chest pain discomfort pressure
_____ Hypertensive disease
_____ Pulmonary congestion & hypostasis (CHF)
_____ Electrolyte/fluid abnormality
_____ Tachycardia/palpitation
_____ Ischemic heart disease (hx MI)
_____ Dizziness
_____ Other

4 **CHEST XRAY:**

_____ Existing pulmonary disease (asthma COPD etc)
Specify _____
_____ Existing cardiac disease (hypertension CHF etc)
_____ Internal injury
_____ Fever
_____ Cough
_____ Disorders of bone & cartilage (arthritis)
_____ Other

5 _____ Antibiotic: _____

6 _____ NPO after midnight

7 _____ ☐ TED or ☐ SCD hose prior to surgery

8 **Other Orders** _____

9 Anesthesia Consult ☐ YES ☐ NO

Signature [signature]

Baptist Medical Center East
PHYSICIAN'S ORDERS

USE BALL POINT PEN ONLY AND PRESS FIRMLY!!

Addressograph Plate

Surgery Sept. 15, 04

Marlon Martin

ALLERGIES

CPT Order # Transcriber Initials/Time	Date/Time Ordered		ANOTHER BRAND OF GENERICALLY EQUIVALENT PRODUCT MAY BE DISPENSED UNLESS CHECKED OR INITIALED
	8/16/04		**PHYSICIAN'S ORDERS AND SIGNATURE**

ROUTINE PRE OPERATIVE ORDERS

DR TM CHUNG

Page 1 of 2

1 Operative permit for Right Knee arthroscopy, anterior cruciate ligament reconstruction with patellar tendon graft

2 **LAB:** ***check appropriate diagnosis***

A ___ **CBC:**
- ___ Pre op patient [V72 83]
- ___ Long term use of medications
- ___ Fever
- ___ Abdominal pain
- ___ Other

B ___ **TYPE & SCREEN**

C ___ **CHEM 7:**
- ___ Edema
- ___ Hypertensive disease
- ___ Long term use of medications
- ___ Diabetic
- ___ Nephropathology
- ___ Dizziness
- ___ Other

D ___ **PT PTT**
- ___ Known or suspected coagulation abnormality
- ___ Anticoagulant therapy
- ___ Hemorrhage or anemia
- ___ Pulmonary congestion
- ___ Other
- ___ Cirrhosis hepatitis
- ___ CHF
- ___ Cardiac dysrhythmia
- ___ Dysfunctional uterine bleedi
- ___ Menorrhagia

E **DRUG LEVELS:** ***circle appropriate drug***
- ___ Patients taking Digoxin Tegretol Theophylline Dilantin Depako
- ___ Phenobarb
- ___ Other

F **URINE PREGNANCY**
- ___ On all menstruating females

G **UA:**
- ___ Diabetic
- ___ Renal glycosuria
- ___ Dehydration
- ___ Stress incontinence
- ___ Fever
- ___ Dysuria
- ___ Abdominal & pelvic pain
- ___ Long term use medicatic

H **ADDITIONAL LAB TESTS:**
- ___ _____
- ___ _____

Facility Name: Staton

Month/Year of Charting: 6/06

Robaxin 500mg PO BID x 10 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6a										X															→	→	→	→	X		
6p										+															→	→	→	→	X	[illegible]	

Start Date: 6/30/06 Prescriber: [illegible signature]

Stop Date: 7/9/06 RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Diagnosis

Allergies: Baclofen

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible signature]	[illegible]		

Documentation Codes
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Housing Unit:

Patient ID Number: 225745

Patient Name: Martin, Marlon

Date of Birth: 12/17/76

Facility Name: Staton

Month/Year of Charting: 5/06

Flexeril 10mg 1 PO Tid x 7 days

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

6A [illegible]

6P [illegible]

Start Date: 4/27/06 Prescriber: Peasant

Stop Date: 5/4/06 RX #:

Robaxin 500mg PO BID x 10 days

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

6a

6p

Start Date: 5/26/06 Prescriber: Peasant

Stop Date: 6/4/06 RX #:

Have not received med @ all.

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Start Date: Prescriber:

Stop Date: RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date: Prescriber:

Stop Date: RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date: Prescriber:

Stop Date: RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date: Prescriber:

Stop Date: RX #:

Diagnosis

Allergies NKA

Housing Unit:

Patient ID Number: 225140

Patient Name: Martin Marlon

Nurse's Signature	Initial	Nurse's Signature	Initial
S. Taylor LPN	ST	J. Parker, LPN	JP

Date of Birth: 12/17/20

Documentation Codes
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Facility Name: SCC

Month/Year of Charting: 3/06

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Naprosyn 375mg
1 p.o. TID x 15 days

6A X
12N X
6P X

DC'd

X X

Start Date: 3/2/06
Stop Date: 3/18/06
Prescriber: Lassiter CRNP
RX #:

Naproxyn 375mg
PO TID x 15 days

6A
12N
6P

Start Date: 3/18/06
Stop Date: 4/2/06
Prescriber: Lassiter CRNP
RX #:

Start Date:
Stop Date:
Prescriber:
RX #:

Start Date:
Stop Date:
Prescriber:
RX #:

Start Date:
Stop Date:
Prescriber:
RX #:

Start Date:
Stop Date:
Prescriber:
RX #:

Diagnosis

Allergies
NKA

Housing Unit:

Patient ID Number: 225140

Patient Name: Martin, Marlon

Nurse's Signature	Initial	Nurse's Signature	Initial
BKennedy	BK	B. Brown	B.

Date of Birth: 12/17/70

Documentation Codes
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Facility Name: Staton Correctional Facility

Month/Year of Charting: 01/06

Naprosyn 375MG Tab 57.00

Take 1 tablet(s) by mouth Three Times Daily

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6A	9	9	9	9	9	9	9																								
12P																															
6P																															

ST

Start Date: 12-20-2005 Prescriber: Peasant, John

Stop Date: 01-07-2006 RX #: 250995466

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date. Prescriber:

Stop Date: RX #:

Diagnosis

Allergies NKA

Housing Unit: Population

Patient ID Number: 225140

Patient Name:

Martin, Marlon

Nurse's Signature	Initial	Nurse's Signature	Initial
Stanney LPN	ST	[illegible signature]	[illegible]
		[illegible signature]	[illegible]
		[illegible signature]	[illegible]

Date of Birth: 12/17/70

Documentation Codes
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Facility Name: Staton

Month/Year of Charting: 12/05

Naprosyn 375mg
÷ PO TID
X 30 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6a						X	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]														
12p						X	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]														
6p						X	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]														

Start Date: 12/7/05 Prescriber: Lassiter CRNP
Stop Date: 1/7/06 RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Diagnosis

Allergies: NKA

Housing Unit:
Patient ID Number: 225140
Patient Name: Martin, Marlon

Nurse's Signature	Initial	Nurse's Signature	Initial
K. Williams	KW		

Documentation Codes
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Date of Birth: 12/12/70

Staton

Facility Name:

Month/Year of Charting:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Hydrocortisone Cream AAA BID X 30(d) ii tubes	6A																															
	6p												ii tubes given 8/13/05 (CH)																			

Start Date: 8/12/05 Prescriber: McArthur, D; PA
Stop Date: 9/12/05 RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Selenium Sulfide Lotion AAA BID X 14(d)	6A																															
	6p												i given 8/13/05																			
													1	2	3	4	5	6	7	8	9	10	11	12	13	14						

Start Date: 8/12/05 Prescriber: McArthur, D; PA
Stop Date: 8/25/05 RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:
Stop Date: RX #:

Diagnosis

Allergies: NKA

Housing Unit: Staton

Patient ID Number:

Patient Name: Martin, Marlon

Nurse's Signature	Initial	Nurse's Signature	Initial
C Heelyn	CH		

Documentation Codes
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Date of Birth: 12/17/70

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29
Hydrocortisone 1% Cream 4/27/05 – 7/26/05	K Op

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 2

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 7/1/05 THROUGH 7/31/05

Physician Pleasant

Telephone No.

Medical Record No 22514

Alt. Physician

Alt. Telephone

ergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By:

Title: RN

Date: 6/30

PATIENT Mattie Marion

PATIENT CODE 225145

ROOM NO.

BED

FACILI

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29
Hydrocortisone 1% cream 4/27/05 - 9/24/05	K OP

MEDICATIONS | HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 6/1/05 THROUGH 6/30/05

Physician

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No.

Allergies NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By:

Title: LPN

Date 5/24/

PATIENT Martin, Marlon

PATIENT CODE 225145

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29
Hydrocortisone 1% cr.	
4-27-05 7-26-05	2 tubes given 4/27/05

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 2

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 5-1-05 THROUGH 5-31-05

Physician Williams, MD — Telephone No. — Medical Record No

Alt. Physician — Alt. Telephone

Allergies NKA — Rehabilitative Potential

Diagnosis

Medicaid Number — Medicare Number — Complete Entries Checked: By: C. Thompson Title: LPN Date: 4/29/0

PATIENT Martin, Marlon — PATIENT CODE 225145 — ROOM NO. — BED — FACILI Ste

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
4/27/05 Hydrocortisone 1% Cream 04/27/05 - 7/26/05		D Marlon Martin 2 tubes given 4/27/05																												

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 04/01/05 THROUGH 04/30/05

Physician Williams, MD

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No.

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: [signature], RN Title: Date: 4/27

PATIENT Martin, Marlon

PATIENT CODE 225145

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDTO:

MEDICATIONS | HOUR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

Hydrocortisone 1% cream 3-15-05 KOP

given 3-15-05 x2 tubes Marlon Martin

Toradol 60mg IM x 1 dose now 5pm 3-15-05 At

Motrin 600mg TID x 7 days start 3-15-05 End GA 12N 6P

start

MEDICATIONS | HOUR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3-15-05 THROUGH 3-31-05

Physician Williams

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No. 22814

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked: By: A. Dyer RN Title: RN Date: 3-1

PATIENT Martin, Marlon

PATIENT CODE 22145 ROOM NO. BED FACILI

MEDICATION ADMINISTRATION RECORD

SCC

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Hydrocortisone cr 40 gm x 60 day 10-18-04 – 12-18-04	K op	given 10/19/04																												

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 12/1/04 THROUGH 12/31/04

Physician Dr Williams

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No. 225148

Allergies NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: [signature]

Title: LPN

Date: 12/30

PATIENT Martin J Manton

PATIENT CODE

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
02/14/05 Selenium Sulfide lotion AAA QD X14d 02/28/05 McArthur PA	6P	→	→	→	→	→	→	→	→	→	→	→	→	→	→															

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 02/01/05 THROUGH 02/28/05

Physician

Alt. Physician D. McArthur PA

Telephone No.

Alt. Telephone

Medical Record No.

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: McClain Title: Lpn Date: 2/14/0[illegible]

PATIENT Martin, Marlon

PATIENT CODE 225/05

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Hydrocortisone Cr. AAA Bid x 30d KOP ii tubes 1/5/05 – 1/6/05		x	x	x	(2) Tube 1/5/05 MS Marlon Martin																									
MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 1/5/05 THROUGH 1/30/05

Physician Dr Williams

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No.

llergies

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: B Beck [signature] Title: Date: 1/5/

PATIENT Martin Marlon

PATIENT CODE 775145

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29
Hydrocortisone cr 60 gm x 60 days 10-18-04 → 12-18-04 KP	K O P 2 tubes given 10/19/04

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 11-1-04 THROUGH 11-30-04

Physician	Telephone No.	Medical Record No
Alt. Physician	Alt. Telephone	
Allergies NKDA	Rehabilitative Potential	

Diagnosis

Medicaid Number	Medicare Number	Complete Entries Checked: By:	Title:	Date:
			11/1/04	

PATIENT	PATIENT CODE	ROOM NO.	BED	FACILI
Martin, Marlon	225145			

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Motrin 600mg TID x 14(d) 9/23/04 → 10/7/04	6A 12N 6P								X																					
Lortab 5mg ii PO Q 6-8 hr x 10(d) 9/23/04 → 10/3/04	6A 12N 6P 12 mid				X																									
Hydrocortisone cream 60gm KOP x 3(d) ii tubes 9/23/04 → 10/24/04	KOP	given 9/24/04																								X				

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 10-1-04 THROUGH 10-31-04

Physician Williams, W

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No. 22514

Allergies

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: C. Hollinger

Title:

Date: 9/26

PATIENT Morton, Marlon

PATIENT CODE 225144

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1–31
10/18/04 Hydrocortisone Cream 60gm X60d KOP Dr. Williams	KOP	2 tubes given 10/19/04 Marlon Martin; X X X

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 10-01-04 THROUGH 10-31-04

Physician Dr. Williams

Telephone No.

Medical Record No. 222145

Alt. Physician D

Alt. Telephone

Allergies NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked: By: [signature] Title: [signature] Date: 10/18

PATIENT Martin, Marlon

PATIENT CODE

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Vicodin II p.o. q 4 hr. PRN x 7 d 9/17/04 — 9/24/04	PRN																													
May be out of knee immobilizer to rest, Keep on when up (toe touch wt bearing) 9/17/04 —	FYI																													
Change drsg PRN, ice pack PRN 9/17/04	FYI																													
~~Toe touch~~ Error 09/20/04																														
Motrin 600, PO tid PRN x ~~60 days~~ 09/20/04 12/20/04	PRN	Revised see below																												
Motrin 600mg TID PRN x 10 days 9-20-04 - 9-30-04	0600 1100 1800	Revised																												
Motrin 600mg TID x 14d 9-23-04 → 10-7-04	6A 12N 6P																													
Robaxin 500mg ii po q 6-8hr x 10 days 9-23-04 → 10-3-04	6A 12N 6P 12MN																													
Hydrocortisone cream 60 gm KOP x 30 days 9/23/04 - 10/24/04 ~~2~~ tubes D. Wilson	KOP	Marlon Martin 9/24/04																												

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 9-1-04 THROUGH 9-30-04

Physician

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No.

Allergies

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: A. Willis Title: LPN Date: 9/17

Drugs

PATIENT Martin, Marlon

PATIENT CODE 225145

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR
Naproxen 375mg + P.O BID X 14 days 5/10/04 - 5/24/04	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3/1/04 THROUGH 5/31/05

Physician Dr. Sonnier

Alt. Physician D. McArthur, P.A

Telephone No.

Alt. Telephone

Medical Record No. 225145

Allergies

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: L. Thompton Title: LPN Date: 5/10

PATIENT Martin, Marlon

PATIENT CODE 225145 ROOM NO. BED FACILIT

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Naproxen 375mg i PO BID x 14days 2/21/04 — 3/16/04	6AM 6pm	[illegible]																												

MEDICATIONS | HOUR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3-1-04 THROUGH 3-31-04

Physician Sonnier, MD

Alt. Physician MC Arthur, PA

Telephone No.

Alt. Telephone

Medical Record No.

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: C. Hill, LPN

Title:

Date: 2/2-

PATIENT Martin, Marlon

PATIENT CODE 225145

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29
Naproxen 375 mg PO BID X 14 d 2/21 - 3/6/04	6A 6P

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 2-1-04 THROUGH 2-29-04

Physician

Alt. Physician McArthur

Telephone No.

Alt. Telephone

Medical Record No.

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: Cottrell-Smith Title: LPN Date: 2/20/04

PATIENT Martin Marlon

PATIENT CODE 225445

ROOM NO.

BED

FACILITY

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Antivert 25mg T PO BID x 30 days (Meclizine) 9/9/03 – 10/9/03	6A 6P																															
MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 10/1/03 THROUGH 10/31/03

Physician Sumner

Alt. Physician

Telephone Number

Alt. Telephone

Inmate No. 225145

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: [signature] Title: RN Date: 10/1/03

PATIENT Martin, Mallory

PATIENT CODE 225145

ROOM NO.

BED

FACILITY CODE DC

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3
07/28/03 Diamox 125mg Po. Bid X 14 days 08/12/03 Dr. Sonnier Au	6A	·	·	·	·	·	·	·	·	·	·	·	·																		·	·
	6p																															
MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 07/01/03 THROUGH 07/31/03

Physician: Sonnier

Alt. Physician:

Telephone Number:

Alt. Telephone:

Inmate No. 225145

Allergies: NKA

Rehabilitative Potential:

Diagnosis:

Medicaid Number:

Medicare Number:

Complete Entries Checked By: D Austin Title: LPN Date: 07/28/03

PATIENT: Martin, Marlon

PATIENT CODE: | ROOM NO.: | BED: | FACILITY CODE: Dranc...

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR	1–31
Minipress 1mg ↑ BID x 14 day 8/25-9/8/03	6A / 6P	[illegible] Complete
Flexeril 10mg ↑ TID x 3 day 8/29-9/1/03	6A / 12N / 6P	[illegible] Complete
9/9/03 – Antivert 25mg PO BID x 30 days 9/9/03 – 10/9/03 [illegible] (meclizine)	6A / 6P	[illegible]
9/9/03 Debrox [illegible] gtts both ears TID x 5 days 9/9/03 – 9/14/03 [illegible]	6A / 12 / 6P	[illegible] 9/10/03 [illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 9/1/03 THROUGH 9/30/03

Physician Dannis

Alt. Physician

Telephone Number

Alt. Telephone

Inmate No. 225145-D[illegible]

Allergies NDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: A. King Title: LPN Date: 9/1/03

PATIENT Martin, Marlon

PATIENT CODE 225145

ROOM NO.

BED

FACILITY CODE

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR	Days 1–31
07/28/03 Diamox 125mg i PO Bid x 14 days 08/12/03 Dr. Sonnier	6A 6p	Rewritten
Diamox 125mg i BID x 14 days 8/3-8/17/03	6A 6P	Order rewritten
Diamox 125mg i BID 8/12/03 x 14 days 8/26/03	6A 6P	Order revised
Diamox 125mg i BID x 30 days 8/12/03 – 9/12/03	6A 6P	[illegible initials]
08/25/03 Minipress 1mg i PO Bid x 14 days 09/08/03 Dr. Helms	6A 6p	[illegible initials]
08/25/03 H.C.A. 1% tid x 14 days KOP 09/08/03 Dr. Helms	KOP	[illegible]
08/29/03 Tylenol 10mg PO TID x 3d 9/1/03 Dr. Sonnier	6A 12N 6p	[illegible initials]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 08/01/03 THROUGH 08/31/03

Physician: Sonnier

Alt. Physician:

Telephone Number:

Alt. Telephone:

Inmate No. 225145

Allergies: NKA

Rehabilitative Potential:

Diagnosis:

Medicaid Number: | Medicare Number:

Complete Entries Checked By: D Austin Title: LPN Date: 07/28/03

PATIENT: Martin, Marlon | PATIENT CODE | ROOM NO. | BED | FACILITY CODE: Draper

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR	1–31 (days)
Diamox 125mg p.o. BID x 14 day 3/11/03 – 3/25/03	6A / 6P	X B B B B B B B B B B B B X (entries days 11–25)
Benzoyl H_2O_2 BID x 30 days KOP 3/11/03 – 3/24/03	KOP	Given 03/12/03 Dawkins Lpn
HC Creme 1% TID x 14 days KOP 3/11/03 – 3/24/03	KOP	Given 03/12/03 Dawkins Lpn

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3/1/03 THROUGH 3/31/03

Physician: Sonnier	Telephone Number	Inmate No. 235145
Alt. Physician	Alt. Telephone	
Allergies: NKA	Rehabilitative Potential	
Diagnosis:		

Medicaid Number	Medicare Number	Complete Entries Checked By:	Title:	Date:

PATIENT	PATIENT CODE	ROOM NO.	BED	FACILITY CODE
Martin, Marlon	235145			DAA

PFS: NAPH

Inmate Name Marlon [illegible] Date of Request 1-12-03

AIS No. 225145 Date of Birth 12-17-70 Housing Loc. 2 Cell Bed 14

Nature of problem or request When i was at Kilby they cleaned my out my right ear and the water hit a nerve causing my balance to be of worst than before my left ear still need cleaning ② when i was at Kilby they took my knee Brace i need one bad my hurts

Sign here for consent to be treated by health staff for the condition described above. Marlon Martin

JAN 12 2003

Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective: my Balance is off Because they Flush my ear, my vision is Blurred. I need a Knee Brace, they took mine that I had.

Objective: BP 120/78 P 78 R 20 T 98 WT 172#

white looking material noted in Ⓛ ear. unable to examine Ⓡ ear clear c no wax

Assessment: alteration in comfort

Plan: MD to Review

1-13-03

8 [illegible]

Refer to: PA/ Physician Mental Health Dental

Education: IN [illegible] Education on Ear wax B [illegible]

Protocol used: (specify) Same as above

Signature M Scott [illegible] 1/13/03 Title ________ Time ________ Date ________

NAPHCARE
PHYSICIAN'S PROGRESS NOTES

DATE	TIME	NOTES MUST BE SIGNED BY PHYSICIAN
1-30-03 @	9:30 AM	See MD or CRNP: vertigo Labs 12/13/03
#167		97.2, 60, 18, 120/80
		[signature]
		33 BM c/o vertigo. [illegible] Tx
		[illegible] NO help. Vertigo happens whenever he is
		working and moves his head too fast
		PE
		Bilat [illegible] TM [illegible]
		Imp
		Labyrinthitis
		plan
		Bactrim DS T P.O BID x 10 days
		[signature]
2-13-03	10:15	162 97.1 68, 20 100/60
		33 BM 3 days S/P 10 days P.O Bactrim
		Neither Antivert or Bactrim helped vertigo
		Heat typically [illegible] dizziness; or
		rigorous activity (basketball) when vertigo is
		at its worst Lt arm & leg cramps & also
		feels top of scalp is somehow involved
		Pt also wants records from Grady in Atlanta
		re: need for Rt knee brace
		Plan
		① ENT consult – ② send for records from Grady [signature]

NAME-LAST	FIRST	MIDDLE	AIS #
Martin	Marlon	Draper	225145

NAPHCARE
NURSE'S NOTES

TIME	
/23/02	Rec'd @ SHCU c VOL.1 and no meds ——— K. Wright
1/6/04	10:30pm arrived @ HCU escorted by DOC officer for FWA. Resp even unlabored ∅ distress noted T 97.2 - P - 55 R 17 O2 97% wt 162# . — R. [illegible]
/2/05	Placed in MOU for FWA on tomorrow BP 100/70, Pulse 60 O2 Sat 97% Temp 97.9 ——— [illegible]

LAST FIRST MIDDLE AIS#